City of Milwaukee
Medical Certification Under the Family & Medical Leave Acts (FMLA)

This medical certification must be provided for all requests for FMLA leave for the serious health condition of the employee or the employee's spouse, parent, or child.

Part A (*To be completed by the Employee):*

Employee:	**Job Title:**
Department:	
Division:	**PeopleSoft ID #:**
Patient's name:	
Relationship to Employee *(If other than employee):*	**Patient's Age** *(If patient Is a child of the employee):*

Part B *(To be completed by the Health Care Provider)*
Please complete this information to allow the employee's request to be approved. The Family & Medical Leave Acts define a serious health condition as illness, injury, impairment or physical or mental condition that involves one or more of the following. Please identify the categories under which the patient's condition qualifies.

☐ **Hospital Care**—Inpatient care *(i.e., an overnight stay)* in a hospital, hospice, or residential medical care facility, including any period of incapacity, or any subsequent treatment in connection with such inpatient care. *For purposes of this section incapacity is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom*.

Absence Plus Treatment—A serious health condition involving continuing treatment by a health care provider that includes a period of incapacity, and any subsequent treatment or period of incapacity relating to the same condition that also involves: *(Incapacity defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.)*

☐ **1.** Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services *(e.g., physical therapist)* under orders of, or on referral by, a health care provider; OR

☐ **2.** Treatment by a health care provider on at least one occasion that results in a regimen of continuing treatment under the supervision of the health care provider.

☐ **Pregnancy**—Continuing treatment by a health care provider for any period of incapacity due to pregnancy, or for prenatal care.

Chronic Condition Requiring Treatment—Continuing treatment by a health care provider for any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one that:

☐ **1.** Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

☐ **2.** Continues over an extended period of time *(including recurring episodes of a single underlying condition*); and

☐ **3.** May cause episodic rather that a continuing period of incapacity *(e.g., asthma, diabetes, epilepsy, etc.)*

☐ **Permanent/Long Term Condition Requiring Supervision**—A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. *Examples include Alzheimer's, a severe stoke, or the terminal stages of a disease.*

☐ **Multiple Treatments/Non-Chronic Condition**—Any period of absence to receive multiple treatments *(including any period of recovery therefrom)* from a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer *(chemotherapy, radiation, etc.)* severe arthritis *(physical therapy)*, kidney disease *(dialysis)*.

The City of Milwaukee also requires the following information from the Health Care Provider in order to determine the employee's eligibility for FMLA. If this information is not provided, the leave will be denied.

1)	Identify and briefly describe the serious health condition:	
2)	Date the serious health condition commenced:	Date of probable end of care: *Must indicate a date unless the condition is chronic.*
	Probable duration of present incapacity if different from date of probable end of care: *(Such as inability to work, attend school, or perform other daily activities due to the serious health condition, treatment therefore or recovery therefrom.) Must indicate an ending date unless the condition is chronic.*	
3)	Is this a chronic condition? YES ☐ NO ☐	If this is a chronic condition, what is the likely frequency of episodes of incapacity?
4)	Within the knowledge of the health care provider or Christian Science practitioner, provide the medical facts regarding the serious health condition that support this medical certification. *Please attach a separate sheet if more space is necessary.*	
5)	If this is family leave, is the employee needed to provide assistance for basic medical or personal needs of safety, or for transportation, or for medical appointments, or making arrangement for care? *Please specify what care the employee will provide.*	
6)	Will it be necessary for the employee to take leave intermittently or to work on a reduced leave schedule (part-time) as a result of the serious health condition? YES ☐ NO ☐	Probable duration of an intermittent or reduced leave schedule: *Please provide an ending date if possible.*
7)	For medical leave (employee's own serious health condition), an explanation of the extent to which the employee is unable to perform his/her employment duties. *Please indicate employee's limitations and the anticipated duration of the restrictions.*	

Health Care Provider's Signature:	***Date:***
Health Care Provider's Name: (please print)	***Health Care Provider's Title:***
Health Care Provider's Address:	***Health Care Provider's Telephone Number:***

Distribution:

- Original – Approving Department
- Employee
- Payroll Assistant

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